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Office of Health Plan Administration
P.O. Box 720724
Sacramento, CA 94229-0724
Telecommunications Device for the Deaf, TTY 1 (800) 795-2929; (916) 795-3240
(916) 795-2515; FAX (916) 795-4105
Toll Free: **888 CalPERS** or **888-**225-7377

February 21, 2007

AGENDA ITEM 8

TO: MEMBERS OF THE HEALTH BENEFITS COMMITTEE

I. SUBJECT: Second Reading –Blue Shield of California's Exclusive Provider Organization and Direct Contract Counties

II. PROGRAM: Health Benefits

III. RECOMMENDATION: Information Only

IV. INTRODUCTION:

At the December 2006 Health Benefits Committee meeting, Blue Shield of California (Blue Shield) outlined four options to address the higher costs of providing health care benefits in its Exclusive Provider Organization (EPO) and Direct Contract (DC) counties. This agenda item provides an initial overview of the four options evaluated.

V. BACKGROUND:

Over the past three years, costs for the DC and EPO counties have been consistently higher than those in Blue Shield's core HMO counties where comprehensive managed care operations are in place. In 2006, Blue Shield estimated the costs for DC counties at 21 percent above those of its core HMO counties, and costs for the EPO counties at 63 percent above those of its core HMO counties.

The mix of CalPERS Blue Shield enrollees between Core HMO and DC/EPO counties further compounds the impact of the DC/EPO costs on the Blue Shield premiums. From 2003 to 2006, Core HMO membership decreased by 75,000 total covered lives (moving from 89 percent to 85 percent of the CalPERS Blue Shield membership) while DC/EPO membership increased by 5,000 total covered lives (moving from 11 percent to 15 percent of the CalPERS Blue Shield membership). This larger percentage of higher cost DC/EPO enrollees translates into higher overall premiums for CalPERS Blue Shield members. The higher costs in the DC/EPO counties, combined with the changing mix of members, indicate that keeping the status quo will pose excessive cost constraints for Blue Shield's overall health benefit plans offered to CalPERS members.

During the development of pricing for 2007, Blue Shield identified the twelve (12) highest cost DC/EPO counties as non-core and proposed at the June 2006 Health Benefits Committee meeting to:

- Discontinue coverage in five of the non-core counties (Colusa, Lake, Mendocino, Plumas, and Sierra); and
- Change the benefit design in eight of the non-core counties (Butte, El Dorado, Glenn, Mariposa, Napa, San Luis Obispo, San Mateo[1] and Sonoma)

At that time, the CalPERS Board and constituents expressed concern about the timing of the proposal and requested that Blue Shield focus on ways to sustain coverage in the non-core counties. In response, Blue Shield created Regional Councils and other activities to identify ways to improve affordability of these non-core counties. The Regional Councils provide education related to health care cost drivers in these non-core counties, sharing recommendations for changes necessary to preserve a managed care model, and seeking assistance from employers and member organization leaders to implement such changes.

As of January 31, 2007, Blue Shield has held meetings in ten of the twelve non-core counties. Meetings in the remaining two non-core counties are scheduled in February and March. These meetings have resulted in action plans projected to save $4.5 million through a variety of targeted actions including:

- Renegotiating inpatient and outpatient rates at hospitals
- Renegotiating physician rates
- Renegotiating laboratory fees
- Increased channeling to Ambulatory Surgery Centers

VI. ANALYSIS:

In examining health care costs in each of the non-core counties, Blue Shield created a ratio (cost-to-premium relativity ratio) that measures the amount of premium required to cover costs in a county versus the average actual amount of premium paid per member in that county. A cost-to-premium relativity ratio of greater than 1.0 means that members in that county are not paying enough premium to cover the actual cost of providing health care in that area. Where the ratio is greater than 1.0, premiums from members in other counties subsidize health care costs in that area.

This analysis reveals that ten of the twelve non-core counties have a cost-to-premium relativity ratio above 1.0 with five of the non-core counties having ratios well in excess of 1.0 (Sonoma, Lake, El Dorado EPO, Napa and Plumas). Blue

[1] Initially, San Mateo was designated as a non-core county. Since then, San Mateo has been designated as a core county due to its higher percentage of membership enrollment in managed care networks.

Shield's projected savings from the Regional Council Action Plans and analysis indicates that, even with the completion of the targeted actions, these five counties will remain significantly above a 1.0 cost-to-premium relativity ratio.

To address the ongoing high cost issue in the DC/EPO counties, Blue Shield has considered four options:

1. Discontinue coverage in some or all of the high cost counties
2. Adjust regional pricing factors to reflect actual costs for contracting agencies
3. Implement a different benefit design in some or all of the high cost counties
4. Develop a program that allows all CalPERS health plans to share in the high costs of these specific counties.

The detail of each option is provided below.

Option 1 – Discontinue Coverage in Highest Cost Non-Core Counties
Discontinuing coverage in the five highest cost counties will result in a premium savings of approximately 3 percent[2] for members in the remaining counties; and, discontinuing coverage in the ten highest will generate a premium savings of approximately 4.5 percent[3]. The five highest cost non-core counties annual combined projected costs exceed premiums by approximately $35 million. For the ten highest cost non-core counties, that combined figure is $55 million. Exiting the five or the ten highest cost non-core counties will cause a member disruption of 16,000 members or 46,000 members, respectively.

Before making a recommendation to modify its current HMO service area, Blue Shield is finalizing its analyses and criteria for possible action at a future Health Benefits Committee meeting.

Option 2 – Regional Pricing to Reflect Actual Costs for Contracting Agencies
Higher cost regions are causing rates to be artificially increased in lower cost regions. For the 2007 rates, the contracting agency regional pricing factor for the Other Northern California region could not exceed 1.13[4] of the statewide premium. Actual cost data for that region, however, suggests a value greater than 1.15. The use of the 1.13 pricing factor for the Other Northern California Region thereby prevented Blue Shield from applying a lower pricing factor to the Los Angeles region and the Other Southern California region. In turn, the resulting higher premium in Southern California limits Blue Shield's and CalPERS' ability to maintain and grow its Southern California membership base.

[2] Projection based on 2007 Basic plan premiums.
[3] Projection based on 2007 Basic plan premiums.
[4] This means the contracting agency premium cannot be more than 13 percent higher than the statewide premium.

A regional pricing increase for the Other Northern California Region could potentially result in the loss of some Blue Shield Northern California members, but will ultimately allow Blue Shield and CalPERS to gain members in Southern California by offering a more competitively priced product. Another benefit of adjusting regional pricing to reflect actual costs is that member premiums will offset the actual cost of providing health care in these high cost areas.

Before making a recommendation to further modify regional pricing for contracting agencies, Blue Shield will finalize its analyses for possible action at a future Health Benefits Committee meeting.

Option 3 – Alternative Benefit Designs

A Point of Service (POS) product would provide members with the flexibility to go outside of the Blue Shield POS network, into the Blue Shield PPO network with an increased coinsurance payment. A POS product provides incentives to members to obtain appropriate levels of care in the most cost-effective setting. Benefit design can shift enrollee utilization to less costly physician office visits, as well as free-standing ambulatory surgery centers (when appropriate), rather than more expensive hospital based services.

Despite the potential benefits of such a plan, Blue Shield has determined that this product will not qualify for the Rural Health Care Equity Program (RHCEP) administered by the Department of Personnel Administration (DPA). Offering a POS plan will therefore, result in higher, non-reimbursable member premiums and the potential for adverse risk selection. Blue Shield will therefore not pursue this option.

Option 4 – Subsidy Program

Blue Shield considered two different options for their Subsidy Program proposal. The first option, the Geographic Subsidy option, focused on those high cost Blue Shield counties where Western Health Advantage (WHA) and Kaiser do not provide coverage and, therefore, all the HMO plans do not share the higher costs in these counties. This means Kaiser and WHA would provide a subsidy to cover Blue Shield's operational costs in the DC/EPO counties. The second option, the Burden of Illness Subsidy, focused on adjusting for the members' health status between all of CalPERS HMO plans.

Blue Shield has determined, however, not to pursue this option due to potential conflicts with PEMHCA provisions regarding premium rates. Blue Shield will therefore not discuss a potential subsidy program at future Health Benefits Committee meetings.

VII. STAFF RECOMMENDATION:

This is an information item.

VIII. STRATEGIC GOAL:

This item supports Goal X of the strategic plan which states, “Develop and administer quality, sustainable health benefits programs that are responsive to and valued by enrollees and employers.”

IX. RESULTS/COSTS:

This is an information item only. Paul Markovich, Senior Vice President, Large Group Business Unit, Blue Shield of California will make a detailed presentation to be distributed at the Health Benefits Committee meeting.

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Beverly R. Craig, Acting Chief
Office of Health Plan Administration

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Sandra Felderstein
Acting Assistant Executive Officer
Health Benefits Branch